Rhode Island Department of Health
Three Capitol Hill
Providence, RI 02908-5094
www.health.ri.gov

Immunize For Life Adult Immunization Program Agreement to Participate

To participate in the *Immunize For Life* Adult Immunization Program and receive state-supplied vaccine at no cost, I agree to the following conditions, on behalf of myself and all the practitioners, nurses and others associated within the medical office, group practice, managed care organization, community/migrant/rural clinic, health department, or health delivery facility of which I am the Medical Director/Lead Physician or equivalent. Our practice/facility and staff agrees to:

1. Enroll in the Immunize For Life Program annually. Enrollment is for a 12-month period (July 1-June 30) and must be completed by June 30th for the following year.
2. Comply with the best practices for immunization administration and the most current immunization schedule as recommended by the Advisory Committee on Immunization Practices (ACIP) unless a) in my medical judgment, and in accordance with accepted medical practice, I deem such compliance to be medically inappropriate; or b) the particular requirement contradicts the law in my state pertaining to immunization exemptions.
3. Keep a current copy of each of the following documents at the practice/facility for use and/or reference: The Department of Health's (HEALTH's) *Adult Vaccine Inventory Report Form* and *Temperature Logs***,** *Its federal law*, current *Vaccine Information Statements* (VIS's) for distribution to patients, the *Vaccine Storage and Handling Checklist*, the notice of *Vaccine Adverse Event Reporting Form* (VAERS) and notice of the *Vaccine Injury Compensation Program* (VICP).
4. Comply with Its federal law and distribute the most current VIS(s) before administering vaccine(s).
5. Maintain an Immunization Record of each vaccine given including the date administered, site, lot number, manufacturer, the publication date on the VIS, the date the VIS was given, and the signature of the person administering the vaccine.
6. Report all vaccine adverse events.
7. Comply with the state's requirements for proper vaccine storage and handling. This includes, but is not limited to: approved temperature monitoring equipment for refrigerator, documentation of twice daily refrigerator temperature checks on the *Temperature Log*, and records of actions taken for refrigerator temperatures outside recommended ranges.
8. Accommodate any state request for an on-site inspection of patient vaccine records, vaccine inventory and/or storage facilities within 60 days of the initial request.
9. Comply with the state's vaccine ordering procedure and submission of monthly inventory and temperature reporting.
10. Not impose a charge to eligible patients for the cost of any state-supplied vaccine.
11. Not use vaccines provided through the Adult Immunization Program to vaccinate children under the age 19 years.
12. Be accountable for all doses of vaccine and submit a reimbursement claim or documentation of uninsured status for the administration of each dose of vaccine. HEALTH will allow a **5%** waste margin to each provider/facility. Any wastage of more than the 5% margin will be deemed excessive and will require payment to HEALTH for the vaccine.
13. Acknowledge that any future program enrollments will be denied until all outstanding financial obligations from the previous year(s) are paid in full to HEALTH.
14. Notify HEALTH should any of the following information for your practice/facility change: practice/facility name, address, phone or fax number, office manager, vaccine contact, lead physician or delivery information.
15. Attend training/information/technical assistance session as required by HEALTH.

This agreement is binding and will remain in effect until: (1) HEALTH terminates this agreement, at any time, for failure to comply with the program requirements (2) the practice terminates this agreement for reasons determined by the Medical Director of the practice or (3) there is a change of the Medical Director (Lead Physician) and/or entity name, or failure to renew annual enrollment.

X_____ ***X***_____***X***_____

Medical Director / Lead Physician (**Print Name**) License Number Medical Director / Lead Physician **Signature**

X_____ ***X***_____

Practice/Facility Name AV Number

X_____ **X**_____

Department of Health Authorized Agent Signature Date